23111

STATE OF GEORGIA CHILD FATALITY REVIEW

Coroner/Medical Examiner Report

Website: www.gacfr.org
email: staff@gacfr.org

Office of Child Fatality Review
Georgia Child Fatality Review Pan
506 Roswell Street, Suite 230
Marietta, Georgia 30060-4101
T:770/528-3988; F:770/528-3989

Instructions:

A. Receive reports of all deaths of children under the age of 18 that occurred in the county.
B. Notify chairperson of the Child Fatality Review Committee (CFRC) within 48 hours of death if decedent is a resident of county.
C. If death meets criteria for review (see Section B), and decedent is resident of county, complete Form 1 in its entirety and forward to the chairperson of the CFRC within 7 days of death.
D. If death does not meet criteria for review, and decedent is resident of county, complete Sections A, B and J of Form 1 and forward to chairperson of CFRC within 7 days of death.
E. If decedent is not a resident of county of death, notify the coroner in the county of residence of the death within 48 hours, and forward a copy of Form 1 to the coroner in the county of residence within 7 days of the child's death.

A. IDENTIFICATION INFORMATION (Decedent)

Decedent's First Name | MI

Last Name

Street Address

City | State | Zip

Date of Birth (MM/DD/YYYY): / /

Date of Death (MM/DD/YYYY): / /

Decedent's SS# (if known): - -

Phone Number (if known): - -

County of Residence

County of Illness/Injury/Event

County of Death

SEX: ○ Male ○ Female

Hispanic Origin? ○ Yes ○ No

RACE: ○ White ○ Black ○ Asian/Pacific Islander ○ American Indian/Alaskan Native ○ Multi-racial ○ Unknown/Other

Natural Mother's First Name | MI

Last Name

Mother's Date of Birth: / /

Natural Father's First Name | MI

Last Name

B. CRITERIA FOR REVIEW

Mark all that apply to this fatality. If one or more indicators are applicable, O.C.G.A 19-15, requires that the death be referred to the Child Fatality Review Committee for review.

Death occurring:

- ○ SIDS
- ○ Any unexpected or unexplained conditions
- ○ Intentional injuries
- ○ Unintentional injuries
- ○ Medical conditions when unattended by a physician unless occurred while the person was a patient of a hospice licensed under Article 9 of Chapter 7 of Title 31)
- ○ Sudden death when child is in apparent good health
- ○ Any suspicious or unusual manner
- ○ When an inmate of a state hospital or a state,county, or city penal institution

Referral to Child Fatality Review Committee

- ○ One or more of the indicators marked above apply in this fatality. Case referred to CFRC for review
- ○ None of the indicators listed apply in this fatality. Case referred to CFRC for information only

Note: If death does not meet criteria for review, list cause of death and a brief description of circumstances:

OCFR Use Only

23111

C. Social Information

For all persons living in the residence of the decedent, indicate their relationhip, age, and who is the head of household. (Select only one head of household).

Relationship	AGE	Head of Household

a. Natural Father
b. Natural Mother
c. Grandfather
d. Grandmother
e. Stepfather
f. Stepmother
g. Foster Father
h. Foster Mother
i. Other Relative
j. Parent's Male Paramour
k. Parent's Female Paramour
l. Other non-relative
m. Sibling
n. More than two children

Current marital status of head of household?

○ Married ○ Widowed ○ Divorced ○ Never married ○ Unknown

History of domestic violence in home of caretaker(s)?

○ Yes ○ No ○ Unknown If YES, by whom? _____

Are other children in family deceased? If YES, Cause of Death? _____

○ Yes ○ No ○ Unknown If YES, age at time of death? ☐☐

D. Supervision

Who was in charge of watching the decedent at the time of injury/illness incident? Check all that apply.

Relationship	AGE

In Charge of Watching Decedent

a. Natural Father
b. Natural Mother
c. Grandfather
d. Grandmother
e. Stepfather
f. Stepmother
g. Foster Father
h. Foster Mother
i. Other Adult Relative
j. Parent's Male Paramour
k. Parent's Female Paramour
l. Licensed Babysitter/Child Care Worker
m. Unlicensed Babysiter/Child Care Worker
n. Child
o. Hospital Staff
p. Other non-relative
q. No one in charge of watching
r. Due to decedent's age, no one in charge
s. Adoptive Father
t. Adoptive Mother
u. Other: _____

Was the decedent adequately supervised? ○ Yes ○ No ○ Unknown ○ Not Applicable

If no, complete questions 1-2.

(1) At the time of the injury/illness event, did the person(s) in charge appear to be:

○ Intoxicated ○ Otherwise impaired (specify) _____ ○ Asleep
○ Under the influence of drugs ○ Preoccupied ○ Absent
○ Mentally ill/limited ○ Distracted ○ Unknown

(2) Is the person(s) responsible for supervising other children?

○ Yes ○ No ○ Unknown

Was the injury/illness event witnessed by anyone other than person(s) responsible for supervision of decedent?

○ Yes ○ No ○ Unknown ○ Not Applicable

OCFR Use Only ☐☐☐☐☐

23111

E. Injury/Illness Scene Information

Place of injury/illness event that resulted in death

- ○ Decedent's home
- ○ Other home
- ○ Hospital
- ○ Highway
- ○ Parking Lot
- ○ Street
- ○ Driveway
- ○ Wooded area
- ○ Licensed child care facility
- ○ Unlicensed child care facility
- ○ Child care residential facility
- ○ Body of water
- ○ Work place
- ○ Rural Road
- ○ School
- ○ Other _____

Date of Injury/Illness Event ☐☐ / ☐☐ / ☐☐☐☐ ○ Date Unknown

Time of Injury/Illness Event ☐☐ : ☐☐ (hour:minute) ○ AM ○ PM ○ Time Unknown

Date Notified ☐☐ / ☐☐ / ☐☐☐☐

Time Notified ☐☐ : ☐☐ (hour:minute) ○ AM ○ PM

Notified by

Name _____ *Position* _____ *Agency* _____

Arrival Time ☐☐ : ☐☐ (hour:minute) ○ AM ○ PM

Time Pronounced Dead ☐☐ : ☐☐ (hour:minute) ○ Non-applicable

Was body found? Y ○ N ○ **If Yes, by whom?** _____

Date Found ☐☐ / ☐☐ / ☐☐☐☐ **Time Found** ☐☐ : ☐☐ (hour:minute) ○ AM ○ FM ○ Unknown

Had body been moved from place of death? Y ○ N ○ **If Yes, by whom?** _____

Investigating Officer _____ *Position* _____ *Agency* _____

Decedent under care of Physician? Y ○ N ○ ***If yes, please fill in the Physician's Information below.***

Physician's First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Physician's Last Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Physician Address (Street) ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **State** ☐☐ **Zip Code** ☐☐☐☐☐ - ☐☐☐☐

Phone #: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Medications Prescribed _____

Decedent transported to _____ *Transported by* _____

Medical Examiner Notified? ○ Yes ○ No ○ Unknown

Date ☐☐ / ☐☐ / ☐☐☐☐ **Time** ☐☐ : ☐☐ ○ AM ○ FM

Autopsy performed? Y ○ N ○ **Blood Alcohol?** Y ○ N ○ **Toxicology?** Y ○ N ○

OCFR Use Only ☐☐☐☐☐

23111

F. CAUSE OF DEATH

Was death caused by: ○ F1. Injury ○ F2. Illness/SIDs/SUID/Other Natural Causes ○ F3. Unknown

1. Was injury caused by an aggressive or assaultive act?
○ Yes ○ No ○ Unknown

Was injury:
○ Intentional ○ Unintentional ○ Unknown

2. Illness or other Natural Cause

Diagnosed Condition _____

Complete questions below if illness or natural cause death in infant <1 year of age

Age at death?
○ 0-24 hours after birth ○ 25 - 48 hours ○ 49 hours - 6 weeks ○ 7 weeks - 6 months ○ 7 months - 1 year

Gestational age at birth?
○ <25 weeks ○ 26-30 weeks ○ 31-37 weeks ○ >37 weeks ○ Unknown

Multiple Birth: Y ○ N ○ **If Yes, #** ☐☐

Birth weight in grams (approximate lbs/oz)?
○ <750 (<1 lb. 10 oz)
○ 750 - 1,499(1 lb. 10 oz to 3 lbs. 5 oz)
○ 1,500 - 2,499(3 lbs. 6 oz to 5 lbs. 5 oz.)
○ >2499 (>5 lbs. 5 oz)
○ Unknown

Total number of prenatal visits?
○ None ○ 1-3 ○ 4-6 ○ 7-10 ○ Unknown

First prenatal visit occurred during?
○ First Trimester ○ Second Trimester ○ Third Trimester ○ Unknown

Decedent regularly exposed to tobacco smoke
○ Before birth ○ After birth ○ Both ○ Unknown

Medical complications during pregnancy?
○ Yes ○ No ○ Unknown

Drug use during pregnancy?
○ Yes ○ No ○ Unknown

Alcohol use during pregnancy?
○ Yes ○ No ○ Unknown

History information provided by:
○ Parent ○ Physician/medical facility ○ Other

3. Unknown Cause (Describe in Section H. Narrative

G. CIRCUMSTANCES OF DEATH

○ Sudden Unexplained Death of Infant or SIDs ○ Firearm ○ Poisoning Overdose
○ Inadequate Care or Neglect ○ Asphyxia ○ Fire/Burn/Smoke Inhalation
○ Vehicular ○ Shaken/Impact Syndrome ○ Other Inflicted Injury *(Describe in Section H)*
○ Drowning ○ Fall Injury ○ Other Circumstances *(Describe in Section H)*

H. NARRATIVE

OCFR Use Only ☐☐☐☐☐

23111

I. DISPOSITION

Who will sign death certificate?

Body released to

List Personal Belongings

Date / /

Received By

Witness

First Name of Next of Kin

Last Name of next of kin

Street Address

City

State

Zip Code -

Phone Number (if known): - -

J. CORONER/MEDICAL EXAMINER INFORMATION

Coroner's/Medical Examiner 's First Name

Coroner's/Medical Examiner's Last Name

If decedent was resident of another county, list name of county and date form forwarded:

County of residence

Date forwarded / /

Date / /

Coroner's/Medical Examiner's Signature

Referral for Review ○ **Yes** ○ **No**

Date / /

Child Fatality Review Committee Chair Signature

Accepted for Review ○ **Yes** ○ **No**

Date / /

Date mailed to Office of Child Fatality Review

Date / /

OCFR Use Only

Submit Reset